

RHODE ISLAND DEPARTMENT OF HEALTH

Utilization Review Application Guidelines

The Rhode Island Department of Health (Department) provides the *Utilization Review Application Guidelines* as an outline for the utilization review application process, but these guidelines do not replace or supersede RIGL 23-17.12, or its accompanying Rules and Regulations, (*R23-17.12-UR*).

ALL UTILIZATION REVIEW APPLICATION SUBMISSIONS MUST BE FORMATTED ACCORDING TO THE FOLLOWING OUTLINE:

I. UTILIZATION REVIEW APPLICATION INFORMATION

TAB A: Application for Certification/Re-certification/Waiver

- \$500 application fee made payable to “General Treasurer, State of Rhode Island” [2.5.1, 2.5.3, & 3.1.2]
 - Note:** Additionally, the Department is required to bill each review agency monthly for the cost of any time spent on activities related to obtaining and sustaining certification. [2.5]
- completed *Application for Certification/Re-certification to Perform Utilization Review* form [3.1.1 & 9.3]
- completed *Application for Certification/Re-certification to Perform Utilization Review Assurances* form [3.1.1]
- completed *Mandatory Addendum to License Application* form [RIGL 5-75]
- letter confirming review agency’s understanding that the entire application will be considered a public document upon certification [3.2.1]
 - Note:** Written requests for specific documents within the review agency’s completed application to be deemed confidential will be considered according to the Department’s *Policy Regarding Proprietary Documents*.
- **Waiver Requests**
 - evidence of current URAC/NCQA accreditation, if applicable [9.1]
 - The sections, as indicated by “(URAC/NCQA)”, are only waived for accredited review agencies that do not perform utilization review for mental health and substance abuse services
 - Note:** If eligible, incorporate URAC or NCQA-approved policies and procedures, applicable to each waived section, within the application. [9.4]
 - evidence of any direct conflict with the *R23-17.12-UR* and those activities that are conducted pursuant to contracts with the state or federal government or under state or federal jurisdictions, if applicable [9.2]
 - Note:** If eligible, incorporate approved policies and procedures, applicable to the areas of direct conflict, within the application. [9.4]

TAB B: Ownership

- ownership listing & description that includes: [3.1.1]
 - the names, addresses, and percent ownership of all owners
 - all officers, directors, and other persons of any subsidiary corporation owning stock
- organizational chart, if review agency is a parent or subsidiary organization [3.1.1]

TAB C: Scope of Services

- list of payors for which the review agency is performing utilization review in Rhode Island and the services it is providing for each client (e.g. medical, mental health, substance abuse, pharmacy, dental, vision, etc., for prospective, concurrent, and/or retrospective assessments) [3.2.2]

TAB D: Delegation Contracts/Agreements

- if any utilization review is delegated, provide a signed copy of the contract/agreement that controls the delegated responsibilities [3.2.4]

TAB E: Liability Insurance

- evidence of liability insurance [3.2.3]

TAB F: Supporting Documentation

- a utilization review plan program description [3.2.17]
- (URAC/NCQA) a description of types, qualifications, roles, and responsibilities of utilization review staff [3.2.8]

II. POLICIES AND PROCEDURES

Provide copies of approved operational policies and procedures that comply with the following:
[3.2.5, 4.1, & 9.4]

TAB G: Hours of Operation

- (URAC/NCQA) a representative must be reasonably accessible to patients, a patient's family, and providers for a minimum of 5 days per week, during normal business in Rhode Island and during the agency's review operations [3.2.9]

TAB H: Complaint Resolution

- a process to resolve patient and provider complaints (e.g. dissatisfaction with quality of care, quality of service, access to care, etc.) [3.2.7]

TAB I: Medical Necessity Standards and Screening Criteria

- provide a description of utilization review standards, criteria, and guidelines used to assess necessity and/or appropriateness [3.2.20]

Note: Review agencies with annualized data reported to the Department totaling less than 500 requests for authorization may request a variance, in writing, from 3.2.20 (following bullets). [3.2.20 g)]

Note: Review agencies using criteria and review procedures provided by another entity may submit evidence to demonstrate that entity's compliance with 3.2.20 (following bullets). [3.2.20 a)]

- (URAC/NCQA) establish, evaluate, and update criteria and review procedures with the consultation of RI licensed/practicing physicians, hospitals and other health care providers in the same specialty as would typically order the services subject to the criteria: [3.2.20]
 - (URAC/NCQA) seek consultation on the criteria and review procedures from at least 5 Rhode Island licensed providers and when applicable to inpatient and/or outpatient hospital services, with the Medical Directors of each Rhode Island licensed hospital [3.2.20 a)]
 - (URAC/NCQA) allow at least a 30 day period for the consulting parties to provide written comments and/or recommendations [3.2.20 b)]
 - (URAC/NCQA) the review agency will not consult with providers who have financial relationships with the review agency other than direct patient care and reasonable compensation for the consultation [3.2.20 d)]
 - (URAC/NCQA) maintain documentation of the comments and recommendations submitted by the consultants and any actions taken by the review agency [3.2.20 e)]
 - (URAC/NCQA) such documentation will be provided to any licensed health care provider, upon request, at a nominal cost that is sufficient to cover copying and mailing expenses [3.2.20 e)]
- (URAC/NCQA) provide review criteria and procedures to Rhode Island licensed hospitals and the Rhode Island Medical Society upon request [3.2.20]

TAB J: Confidentiality

- assurance to all applicable state and federal laws to protect the confidentiality of individual medical records and the distribution of health care information [2.9, 2.11, & 3.2.10]
- assurance that the review agency will only review information or data that is relevant to the utilization review process [2.10]

TAB K Patient Interviews

- utilization review staff will notify provider operations staff before conducting onsite reviews and/or patient interviews [3.2.11 a)]
- utilization review staff will identify themselves by name and by the name of the review agency and display picture identification on the review agency's company identification card at all times when conducting on-site reviews [3.2.11 b)]
- patient interviews will not unreasonably disrupt provider operations, patient care, or patient privacy [3.2.11 c)]
- the review agency will maintain clear documentation of the patient interviews [3.2.11 d)]
- assurance that the review agency will not conduct patient interviews for inpatient mental health and substance abuse services [3.2.11 e)]

TAB L: Adverse Determinations and Internal Appeals Process

Requirements for All Levels of Review

- no reviewer will be compensated, paid a bonus, or given an incentive, based on making an adverse determination [4.1.8]
- maintain clear documentation of the ordering provider's original requests and any negotiation/agreement to accept an alternative treatment/modified extension of stay [4.1.1]
- assurance that the negotiation/agreement between the review agency and the ordering provider is not coerced by the review agency or its reviewers [4.1.2]
- if the review agency is unable to make a decision, due to insufficient information, the review agency will notify the patient and provider of the specific information required to complete the review, using the adverse determination notification timeframes (from the date of request), listed under “**Notification Timeframes for Initial Adverse Determinations**” on page 6 and “**Notification Timeframes for Internal Appeals**” on page 7 [4.1.4]
 - the review agency may provide the following extension timeframes to receive the necessary information: [4.1.4 a)]
 - a 72 hour extension for urgent/emergent cases [4.1.4 a)]
 - a 15 day extension for non-urgent cases [4.1.4 a)]
- provisions that if a patient or provider does not release the necessary information to the utilization review agency, the utilization review agency may deny certification administratively [4.1.3]
- (URAC/NCQA) the review agency will not retrospectively deny authorizations unless: [4.1.5]
 - (URAC/NCQA) an authorization was based upon inaccurate information pertinent to the review; or [4.1.5]
 - (URAC/NCQA) the health care services were not provided consistent with the provider's submitted plan of care and/or any restrictions included in the review agency's prior authorization [4.1.5]
- the review agency must provide the following when notifying the patient and provider(s) of any adverse determination: [4.2 & 4.2.4]
 - the principal reasons for the adverse determination, including explicit documentation of criteria not met and/or the clinical rationale used by the reviewer in making the adverse determination; [4.2.1]
 - the procedures to initiate an appeal of the adverse determination, including the review agency's contact information (i.e., name/telephone number), and a reasonable period of time (not to be less than 60 days from the notice of the adverse determination) for appeals to be filed for consideration; and [4.2.2 & 6.1.1]
 - (URAC/NCQA) the necessary contact information to complete the two-way direct communication provided for in the following “**Peer to Peer Requirements**” [4.2.3]

Peer to Peer Requirements

- (URAC/NCQA) when making adverse determinations, the licensed review practitioner must be reasonably available to review the case according to all of the following requirements: [4.1.7 a)]
 - (URAC/NCQA) the review agency's Peer Reviewer will have access to and review all necessary information as requested by the review agency and/or submitted by the provider(s) and/or patients [4.1.7 a) (i)]
 - (URAC/NCQA) the review agency will provide accurate peer review contact information to the provider at the time of service, if requested, and/or prior to the

- service, if requested [4.1.7 a) (ii)]
- (URAC/NCQA) the review agency's Peer Reviewer must respond to the provider's request for a two-way direct communication prior to the initial adverse determination according to the following timeframes for: [4.1.7 a) (iii)]
 - (URAC/NCQA) prospective and concurrent reviews of urgent and emergent health care services, within a reasonable period of time of the request for the peer discussion [4.1.7 a) (iii) B]
 - (URAC/NCQA) prospective reviews of non-urgent and non-emergent health care services, within 1 business day of the request for a peer discussion [4.1.7 a) (iii) A]
 - (URAC/NCQA) retrospective reviews, prior to the first level appeal decision [4.1.7 a) (iii) C]
- (URAC/NCQA) at least 2 documented attempts to contact the patient's attending provider directly must be made to complete the two-way direct communication (telephone conversations, fax or electronic transmissions, if mutually agreed upon) when requested and/or as required prior to the first level of appeal [4.1.7 a) (iv) A]
- (URAC/NCQA) a first level appeal adverse determination will not be made until there is evidence that an appropriately qualified and licensed practitioner has provided for a two-way direct communication with the patient's attending practitioner, unless the attending provider: [6.1.5]
 - (URAC/NCQA) is not reasonably available; [6.1.5 a)]
 - (URAC/NCQA) chooses not to speak with agency staff; or [6.1.5 b)]
 - (URAC/NCQA) requests a peer to peer communication prior to the initial adverse determination [6.1.5 d)]
 - (URAC/NCQA) the review agency must maintain documentation of the attending provider's request for the two-way direct communication prior to the initial adverse determination [6.1.5 d), (i)]

Initial Adverse Determinations

- all initial prospective and concurrent adverse determinations, and retrospective adverse determinations for emergent health care services must be made, signed, and documented by a practitioner with the same licensure status as the ordering practitioner [3.2.8 & 5.1.1]
 - prior to any discussions between the review agency staff and the health care facility or office personnel regarding alternative service or treatment options, the review agency must: [5.1.1 a) i)]
 - obtain written documentation from the attending provider, or designee, that specifies the name and title of the personnel authorized to conduct such discussions; and [5.1.1 a) i)]
 - provide written documentation to the attending provider, or designee, indicating the qualified review agency staff's name and title engaging in the discussions [5.1.1 a) i)]
- the concurrent review process must take into consideration the transition of care of the patient, the time of day of discharge, the patient's transportation limitations, the welfare and safety of the patient, etc. [5.1.1 b) i), ii), iii), & iv)]
- all initial retrospective adverse determinations for non-emergency health care services must be made according to written guidelines that have been: [5.1.2 a) & b)]
 - reviewed by local participating and practicing providers; and [5.1.2 a)]
 - signed by the appropriately qualified and licensed practitioner responsible for the implementation of the utilization review program [5.1.2 b)]

Notification Timeframes for Initial Adverse Determinations

- notification of initial prospective adverse determinations must be mailed or otherwise communicated to the patient and provider of record within: [5.1.3]
 - 72 hours of receipt of all necessary information to complete a review of urgent/emergent health care services; [5.1.3 b)]
 - 15 business days of receipt of all necessary information to complete a review of non-urgent/non-emergent health care services; and [5.1.3 a)]
 - prior to the expected date of service [5.1.3 c)]
- notification of initial concurrent adverse determinations must be mailed or otherwise communicated to the: [5.1.4]
 - provider(s) prior to the end of the current certified period; and [5.1.4 a)]
 - patient within 1 business day of making the adverse determination [5.1.4 b)]
- notification of initial retrospective adverse determinations must be mailed or otherwise communicated to the patient and provider of record within: [5.1.5]
 - 30 business days of receipt of a request for payment and all supporting documentation for the covered benefit being reviewed [5.1.5]

Internal Appeals

- no reviewer involved in prior reviews of the case or direct care of the patient may participate as the only reviewer on appeal unless new information has been made available at the first level appeal [4.1.9]
- an expedited appeal process for emergent health care services must be provided [6.1.3]
- a first level internal appeals process must be offered to the patient and provider of record and all first level adverse determinations must be made, signed, and documented by a practitioner with the same licensure status as the ordering practitioner or a licensed physician/dentist [6.1.4]
- a second level internal appeals process must be offered to the patient and provider of record where a first level appeal is unsuccessful and all second level adverse determinations must be made, signed, and documented by a practitioner with the same licensure status as the ordering practitioner or a licensed physician in the same or similar general specialty as typically manages the medical condition/procedure/treatment under discussion [6.1.6 & 6.1.8]
- prior to reaching a final decision at the second level of appeal, the review agency will afford the appellant an opportunity to inspect and add information to the utilization review file [6.1.7]
- (URAC/NCQA) written notification of a second level appeal adverse determination, to the patient and provider of record, must include: [6.1.9]
 - (URAC/NCQA) notice that the patient and provider of record may appeal to the state designated external appeals agencies; [6.1.9 a)]
 - (URAC/NCQA) instructions to initiate the external appeal; [6.1.9 b)]
 - (URAC/NCQA) the fee requirements for completing the external appeal; and [6.1.9 c)]
 - (URAC/NCQA) a statement that if the decision of the review agency is overturned by the external appeals agency, the appellant will be reimbursed by the review agency within 60 days of the notice of overturn for their share of the appeal fee paid [6.1.9 d)]

Notification Timeframes for Internal Appeals

- notification of expedited appeal decisions must be provided to the patient and provider of record within 2 business days of the date the appeal is filed and all information necessary to complete the appeal is received by the review agency [6.1.3]
- written notification of appeal decisions must be provided to the patient and provider of record within: [6.1.2]
 - 15 business days after receipt of the required documentation [6.1.2]
 - if verbal appeal notice is provided within the 15 business days, written notification will be given within 21 business days of receipt of the required documentation [6.1.2]

TAB M: External Appeals of Adverse Determinations

- (URAC/NCQA) an external appeal process, with the designated external appeals agency, must be offered to the patient and provider of record where a second level appeal is unsuccessful [7.1]
- (URAC/NCQA) to initiate an external appeal, the patient or provider of record will file written notification of the appeal with the review agency that made the adverse determination, including a check payable to the external appeals agency for ½ the pre-determined fee [7.4.1]
 - (URAC/NCQA) an external appeal may be filed within 60 days of receipt of the second level appeal adverse determination [7.4.1 b)]
- (URAC/NCQA) the review agency will forward the following to the external appeals agency within 5 business days of receipt of written notification: [7.4.2]
 - (URAC/NCQA) the complete utilization review file, including the specific findings of the adverse determination; [7.4.2 a)]
 - (URAC/NCQA) the specific criteria used in making the adverse determination; and [7.4.2 b)]
 - (URAC/NCQA) payment for the external review fee [7.4.2 c)]
- (URAC/NCQA) if the review agency's decision is overturned by the external appeals agency, the appellant will be reimbursed by the review agency within 60 days of the notice of the overturn for their share of the appeal fee paid [7.4.1 c)]

III. ADVERSE DETERMINATION NOTIFICATIONS

TAB N: Sample Adverse Determination Notification Letters

Note: Template letters will not be accepted.

Sample letters must: [3.2.16, 4.2, & 6.1.1]

- be on the review agency's letterhead
- reflect letters that are sent to the patient and provider(s) of records, including fictitious names, health care services, reasons, etc.
- provide descriptive reasons/clinical rationale/documentation of criteria not met for the adverse determination that are case-specific and criteria-specific
- provide instructions to initiate the next level of appeal, including an appeal time period of at least 60 days from adverse determination notice
- provide appeal contact information, including the name, address, telephone number, fax, etc.
- (URAC/NCQA) provide contact information for the two-way direct (peer to peer) communication provided for in 6.1.5

- Initial adverse determination letter (prospective, concurrent, and retrospective)
- Level I appeal denial letter
 - provide the appellant an opportunity to inspect and add information to the utilization review file for Level II appeal [6.1.7]
- Level II appeal denial letter
 - (URAC/NCQA) provide instructions to initiate an external appeal, including the name of the state-designated external appeals agency and the fee requirements for completing such appeal [6.1.9 a), b), c), & 7.1]
 - (URAC/NCQA) include a statement that if the review agency's decision is overturned by the external appeals agency, the appellant will be reimbursed by the review agency within 60 days of the notice of overturn for their share of the appeal fee paid [6.1.9 d)]

IV. ENROLLEE INFORMATION

TAB O: Informational Materials

- copy of materials used to inform enrollees of the health benefit plan: [3.2.15]
 - requirements for seeking pre-certification or obtaining notification [3.2.15]
 - utilization review process, including appeal rights of RIGL 23-17.12 [3.2.15]

V. EXTERNAL REVIEW CONTRACTS

TAB P: Memoranda of Understanding (MOU)

- (URAC/NCQA) signed copy of the Memoranda of Understanding (MOU) with the designated external appeals agency identified below: [3.2.21 & 7.4]
 - MAXIMUS Center for Health Dispute Resolution
50 Square Drive, Suite 210
Victor, NY 14564-1099
Contact: State Appeals Department
Phone: (585) 425-5280
Fax: (585) 425-5296